STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
OFFICE OF FINANCIAL AND INSURANCE REGULATION
Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXXX
Petitioner **File No. 121571-001**
v

Blue Cross Blue Shield of Michigan
Respondent
_____/

Issued and entered
this _____ day of October 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On May 19, 2011, XXXXX, authorized representative of XXXXX (Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. The Commissioner reviewed the request and accepted it on June 1, 2011.

The Commissioner notified Blue Cross Blue Shield of Michigan (BCBSM) of the external review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on June 9, 2011.

The issue in this external review can be decided by a contractual analysis. The contract here is the BCBSM *Community Blue Group Benefits Certificate* (the certificate). The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II. FACTUAL BACKGROUND

Petitioner is an 8 year old boy, born on April 20, 2003. In 2008 he was diagnosed with a

developmental speech disorder and muscle weakness at the Easter Seals XXXXX and the XXXXX Region (XXXXX) Treatment Facility. Petitioner began receiving treatment for these disorders in June of 2009. BCBSM provided coverage for the therapy from June 18, 2008 through June 17, 2010. BCBSM has denied coverage for therapy provided after June 17, 2010. BCBSM stated that the earlier payments were made in error, but that they did not intend to seek repayment for the costs.

The Petitioner appealed the denial through BCBSM's internal grievance process. BCBSM held a managerial-level conference on March 23, 2011, and issued a final adverse determination dated April 18, 2011.

III. ISSUE

Did BCBSM correctly deny the Petitioner's claims for occupational and speech therapy beyond June 7, 2010?

IV. ANALYSIS

Petitioner's Argument

The Petitioner received therapy services from June 18, 2008, through May 19, 2011 through XXXXX. This care was covered by BCBSM for the period of June 18, 2008 through June 17, 2010. Coverage for therapy provided from June 18, 2010, through May 19, 2011 was denied by BCBSM.

Petitioner's authorized representative believes BCBSM is required to cover the services because (1) the certificate does not contain language requiring services be billed by a physician, and (2) Petitioner's certificate includes the BlueCard PPO, which provides payment for treatment outside of Michigan.

Petitioner's representative states:

> [Petitioner] has been receiving speech and occupational therapy at Easter Seals XXXXX and The XXXXX. In XXXXX since June 18, 2008. XXXXX had pre-verified those therapies with Blue Cross Blue Shield of Michigan ("BCBS-MI") prior to June 18, 2008. Before [Petitioner] received his first therapy session at XXXXXX BCBS-MI had confirmed that speech and occupational therapies were covered benefits under the terms of the applicable policy of insurance (the "Policy").
>
> The relevant terms and conditions of the policy have not been changed since June 18, 2008. However, since June 17, 2010 BCBS-MI has denied [Petitioner's]

> claims for speech and occupational therapy.
>
> According to BCBS-MI's April 18, 2011 letter, BCBS-MI denied [Petitioner's] claims in this instance "[b]ecause occupational and speech therapy are not payable directly to a therapist…" … BCBS-MI based its denial upon the premise that "services performed in the office *must be billed by the physician who employs* the certified speech-language pathologist and/or registered occupational therapist.". BCBS-MI referenced several Policy provisions in its denial letter, but none of BCBS-MI's favorite Policy provisions requires that the physician employ the therapist or do his or her billing directly. [Italics in original]

Petitioner argues that BCBSM based its denial on language that does not appear in the certificate. The Petitioner also noted that BCBSM did not challenge Petitioner's eligibility for coverage. Petitioner is covered by the BlueCard Program. Under that program members of a plan issued in one state may receive services in another. Petitioner's representative states, "[I]t is important to note that [Petitioner] is enrolled in the BlueCard Program. Under that program members of a plan issued in one state (i.e., the Home Plan) may receive services in another area (i.e., the Host Plan).

Because XXXXXX bills all of their insurance carriers in the same way, including BCBS of XXXXX, Petitioner argues that BSBSM cannot deny the claims on the basis that they were not billed by a Physician.

BCBSM's Argument

BCBSM says it administers health care benefits pursuant to the contract language. In its final adverse determination BCBSM denied Payment for Petitioner's therapy stating:

> The certificate does not provide for the direct reimbursement to speech and/or occupational therapists; services performed in the office setting must be billed by the physician who employs the certified speech-language pathologist and/or registered occupational therapist.
>
> Your son's services were not billed by a physician, and the XXXXX Easter Seals Therapy Center is not a participating freestanding facility; therefore, payment is not available under the Physician/Provider or the Hospital/Facility portion of your coverage.

Commissioner's Review

The certificate is clear, in order for occupational and speech therapy to be covered, the services must be: (1) billed by a physician, and (2) provided by a participating facility.

In Section 3 of the certificate, "Coverage for Hospital, Facility and Alternatives to Hospital Care," it says (quoted above) that services provided and billed by a freestanding outpatient physical therapy facility will only be covered when that facility participates with BCBSM.

> **Freestanding Outpatient Physical Therapy Facility Services**
>
> We pay for services in a freestanding outpatient physical therapy facility only when the facility that provides and bills for them is a **participating** facility. (Page 3.28)

Section 4 of the certificate, "Coverage for Physician and Other Professional Provider Services**,"** also describes coverage criteria for speech therapy (page 4.16):

> **Physician and Other Professional Provider Services**
>
> **Physical, Speech and Language Pathology and Occupational Therapy Services**
>
> We pay for physician services for physical therapy, speech and language pathology services, and occupational therapy when provided for rehabilitation.
>
> Speech and language pathology services must be:
>
> - Prescribed by a physician licensed to prescribe them, and
> - Given for a condition that can be significantly improved in a reasonable and generally predictable period of time (usually about six months), and
> - Given by a speech-language pathologist licensed by the American Speech-Language-Hearing Association or by one fulfilling the clinical fellowship year under the supervision of a speech-language pathologist
>
> Occupational therapy must be:
>
> - Prescribed by a physician licensed to prescribe them, and
> - Given for a condition that can be significantly improved in a reasonable and generally predicable period of time (usually about six months), and
> - Given only by a registered occupational therapist or occupational therapy assistant (both must be certified by the National Board of Occupational Therapy Certification and the state of Michigan)
>
> NOTE: The occupational therapy assistance must be under the direct supervision

> of a registered occupational therapist who cosigns all assessments and patients' progress notes. (Pages 4.15-4.18)

Section 3 deals with occupational/speech therapy that is provided in an office setting and billed directly by a physician or other professional provider. Section 4 of the certificate does not apply when the therapy is provided by and billed by a nonparticipating freestanding outpatient physical therapy facility like XXXXX. Because XXXXX does not participate with BCBSM, the therapy rendered there is not a covered benefit even if it is medically necessary, prescribed by a physician, and the therapist is appropriately licensed.

BCBSM's certificate states that "[w]e pay physician services" for speech and occupational therapy." Because the XXXXX Easter Seals Treatment Center bills directly for the provider and not through a physician and is not listed as a BCBS-XX panel physician under the terms of the PPO certificate, BCBSM's denial of coverage is correct.

The Commissioner finds that BCBSM's denial of payment was consistent with the terms of the certificate.

V. ORDER

BCBSM's final adverse determination of April 18, 2011 is upheld. BCBSM is not required to cover Petitioner's therapy beyond June 7, 2010.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court in Michigan, for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

_____

R. Kevin Clinton
Commissioner